PATIENT INFORMATION & MEDICAL HISTORY UPDATE

All questions contained in this questionnaire are strictly confidential and will become part of the patient's record. A Medical History Update must be provided at ***every*** dental visit.

INDICATE CHANGES TO THE FOLLOWING (check all that apply):

☐ MARITAL STATUS ☐ INSURANCE ☐ ADDRESS/PHONE/EMAIL ☐ GUARDIANSHIP

GENERAL INFORMATION

Who is accompanying the children on the date of their appointment? _____
(First & Last Name)

Relation to patients: ☐ Biological ☐ Adopted ☐ Foster ☐ Nanny ☐ Other: _____

Are any of the children a ward of the state? ☐ Yes ☐ NO If yes, case worker's contact number: _____

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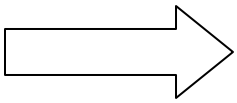
*Please list **FIRST & LAST NAME** of all children being seen for treatment.* 	**Patient's First & Last Name:**	**Patient's First & Last Name:**
	Date of Birth:	**Date of Birth:**
Does the patient have any MEDICAL CONDITIONS? If YES, what conditions? (For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal Allergies, etc)	☐Yes ☐No	☐Yes ☐No
Does the patient have any HEART conditions? (For example: Heart Murmur, Congenital Heart Defect, etc)	☐Yes ☐No	☐Yes ☐No
Is the patient followed by a specialist? If YES, provide name & contact info (For example: Cardiologist, Pulmonologist, etc)	☐Yes ☐No	☐Yes ☐No
Does the patient require an ANTIBIOTIC before being seen? **If YES, did the patient take the antibiotic?**	☐Yes ☐No ☐Yes ☐No	☐Yes ☐No ☐Yes ☐No
Does the patient have an ALLERGY to LATEX?	☐Yes ☐No	☐Yes ☐No
Does the patient have an ALLERGY to TREENUTS?	☐Yes ☐No	☐Yes ☐No
Does the patient have any OTHER ALLERGIES? If YES, what allergies? (For example: Animals, Foods, Medications, Nickel, etc)	☐Yes ☐No	☐Yes ☐No
Is the patient currently taking ANY medications? If YES, please list	☐Yes ☐No	☐Yes ☐No
Is the patient taking any vitamins?	☐Yes ☐No	☐Yes ☐No
Do you (or the patient) have any DENTAL CONCERNS? If YES, please explain	☐Yes ☐No	☐Yes ☐No
CONSENT FOR TODAY: *Consent is given for Fishers Pediatric Dentistry to provide treatment to the patient(**s**) listed above.*		
X-rays (if needed): ***Essential for diagnosing tooth decay and other abnormalities***	☐Yes ☐No	☐Yes ☐No
Fluoride Application: ***To help fight tooth decay and strengthen developing teeth***	☐Yes ☐No	☐Yes ☐No

FRONT & BACK 

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Below is a list of ways that our office may contact you. Please check all that apply. Checking a box will give permission to leave as thorough of a message as needed.

☐ **PHONE NUMBER:** _____ ☐ **EMAIL:**_____

You will receive text message communications to the cell number provided related to appointment reminders, healthcare information and billing matters. Please note you may be charged message and data rates by my wireless carrier. Such messages may be generated by an automated messaging system, and you may opt-out of this service by replying ***STOP*** *to any message.*

In the event of your absence, the following individual(s) may bring your child/children to and from their appointments along with have access to medical and financial information.

Patient Authorization for Use and Disclosure of Protected Health Information:
I authorize Fishers Pediatric Dentistry to release any information including diagnosis and the records regarding any treatment or examination rendered to my child/children during the period of such dental care to third party payers and/or other health practitioners.

FIRST NAME: LAST NAME: RELATIONSHIP: CONTACT #:

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I understand that I can request a copy of this office's Notice of Privacy Practices: ***(initial)*** ☐

OFFICE POLICIES / FINANCIAL AGREEMENT

I certify that the information I have given is correct to the best of my knowledge. It will be held in confidence, and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly Fishers Pediatric Dentistry all insurance payments otherwise payable to me. **I understand that I am responsible for the full balance of the account regardless of my dental benefits.** I acknowledge that the office operates on a **15-day billing cycle** and account balances are due and payable when the statement is issued and is past due if not paid by the date printed on the statement. Past due accounts will incur late charges between **$10 and $25** and can be sent to a collection agency if unpaid. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist or any member of the staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. **I affirm that my signature represents my agreement to all the above mentioned terms.**

Print First & Last Name:_____ **Signature:**_____ **Date:**_____

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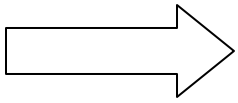
*Please list **FIRST & LAST NAME** of all children being seen for treatment.* 	**Patient's First & Last Name:** **Date of Birth:**	**Patient's First & Last Name:** **Date of Birth:**
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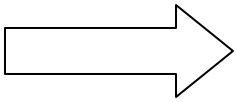
*Please list **FIRST & LAST NAME** of all children being seen for treatment.* 	**Patient's First & Last Name:** **Date of Birth:**	**Patient's First & Last Name:** **Date of Birth:**
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